Utah Digital Health Commission Meeting Minutes

Thursday March 19, 2009
10:00 a.m. -12:00 p.m.
Room 132
Utah Department of Health
288 North 1460 West
Salt Lake City, Utah

Minutes

Members Present: Joseph Cramer (Chair), Rulon Barlow, Scott Barlow, Natalie Gochnour, Deb LaMarche, Chet Loftis, Mark Probst and Jan Root, Nancy Staggers
Via Video Conferencing Brad LeBaron (Vice Chair), and Dennis Moser
Members Absent: Mark Munger
Staff Members: Humaira Shah and Wu Xu (UDOH, Office of Public Health Informatics)
Guests: Don Beckwith (UDOH), Marc Bennett (HealthInsight), Libbey Chuy (AUCH), Sharon Donnelly (HealthInsight), Jeffrey Hawley (Insurance Department), Barry Nangle (UDOH), Bette Vierra (AUCH) and Via Telephone: Mark Fotheringham (Utah Medical Association)

Introduction and Update:

Brad LeBaron, Vice Chair, called the meeting to order. Scott Barlow moved to approve the minutes from the previous meeting; Jan Root seconded, with the change that Dennis Moser was in attendance by telephone.

2009 Legislative Session:

Barry Nangle updated the commission that the health care reform package had four legislations. House Bill 188 was the primary health care reform legislation that allowed employers to offer employees the ability to take employers contribution, go on a private health care market, and purchase health care coverage privately. The state offers a digital health service in the sense that it offers an internet portal that helps people shop for that. Included in this was the removal of certain mandates about what has to be covered in health insurance so that scaled down policies could be available. The other three pieces were Senate Bill 79, which was malpractice reform, and E.R. malpractice reform. House Bill 165 was administrative simplification. House Bill 331 required that state contractors of a certain size cover employees' health insurance. More related to digital health services was House Bill 128, the e-prescribing bill and it was sponsored by Representative Menlove. The Electronic Prescribing Act was the bill that was first brought before this committee for input. Representative Menlove got a great deal of feedback from the commission, and modified the bill which helped it to be passed. E-prescribing is not effective immediately but made e-prescribing something providers had to offer to their patients by July 2012.

Jan Root said that she thought H.B.165 had provision for a standard ID card for payers to offer, and then she asked if it had a swipe card technology included. Chet Loftis said it has standard features on the ID card; everyone has the same information; and it empowers the insurance commissioner to come up with a plan to use swipe card technology. Jan mentioned that there is a federal standard for the enrollment message that's part of HIPPA.

Brad asked if any member from the commission needed to be renewed. Wu Xu answered that it will be in 2010.

Review HIT Funding Opportunities in the American Recovery and Reinvestment Act (ARRA) and Community Coordination:

Sharon Donnelly explained that one of the main things the act did was codify the ONCHIT office. It gave some money and assigned some work to NIST (National Institute for Standard Technology). The HIT extension program is at the federal level on ONCHIT to have a central federal resource center; and the HIT regional extension centers are on the ground out in the states. They wanted to get partners together that provide EHR/HIT adoption assistance in physician offices, nursing homes, home health agencies and small hospitals. The Department of Health and UMA had funded *HealthInsight* to do this work. She hadn't heard of any entity in Utah looking at a planning grant because they are mostly for communities that aren't as far along as they are, particularly with the clinical health information exchange (cHIE). The loan program is looking at low interest loans for buying the software, training expenses and/or connecting to the cHIE. HealthInsight had started by doing an environmental scan and talking to physicians, hospitals and nursing homes, seeing how much demand there is.

Mark Fotheringham said that if there are a lot of strings attached to the loan, there will be less interest in the program. The community was trying to get a feel for how much need and interest there is in the program. If there is need and interest, the next step would be asking for the right partners to put together a proposal to bring the program to Utah.

Sharon talked about the educational programs. The University of Utah is interested in working on some of those educational programs and training information technology professionals in health care. Nancy Staggers said they had talked about making some of the programs with distance learning capability and making them more accessible around the western region.

Sharon then talked about the incentives. Providers can have the Medicaid or Medicare incentives but not both. The Medicare incentive is essentially you show that you meet some criteria that you have a certified EHR in place. If there is a cHIE available, are you connecting to it and reporting on clinical quality measures. HealthInsight is working with clinics now to try to get them started by 2011 so they are eligible.

Scott asked how many offices and sites are going to qualify given the 20% - 30% caseload thresholds? Sharon assumed the number to be very small. Wu said she checked with the CMS on the definition of Medicaid eligible and they said that all the needy individuals are eligible. She agreed that it's a small number of clinics; you may increase your percentage by other needy individuals.

Jan said that this is an economic stimulus; small businesses fail because of high health care cost, employee absenteeism and other things having to do with health care. We need to improve the quality of care and reduce the cost of care in America. America ranks the 1st in cost and 39th in quality. She then said that they are looking at how much training it takes to bring up one physician on an EMR; it is about 40-50 hours per provider; and Utah has about 4,000-6,000 physicians.

Natalie Gochnour asked that given that we are a progressive state in this area, do we had a sense of how much money is going to come this way? Wu answered that we tried to bring interested parties together and come out with possible proposals. Barry added that we're 1% of the U.S. population; and that hopefully we get more than 1% of this funding. Deb LaMarche said that Utah plays a key role in health care in the intermountain west, not just in our state, so it seems like we should be able to have a bigger pot than 1%.

Natalie said that in the business community we're making a big deal about all the money that's coming for all the other things. We've done a news release on a federal bidding for a project that's paid for with stimulus dollars and have estimated the job impact of this.

Marc Probst thought that Utah should go in a coordinated fashion in what we're doing, and not send a bunch of competing proposals for the dollars that are on the table. We're going to be extremely unique to other states and could increase our opportunities further.

Nancy asked if we know where we can get more information. Wu answered that in one of the summaries, it says that grants will come from ONC, CDC, CMS, HRSA, and AHRQ. She has heard three grant channels right now from the CDC public health informatics centers' renewal, the commission-overseen and ONC funded HISPC project extension, and the NIH Challenge Grants.

E-health Community Initiative:

Mr. Cramer said there is a funding request for 2 million dollars to support e-health community initiatives. A section of the e-community health proposal seems like a perfect opportunity in light of what has been discussed about with Cache County. Along with it is the UHIN's proposal of pilot places where they want to initiate their health information exchange. The health department and the commission would be the applicants of this grant. The activities include the facilitation of initiatives, as well as technical assistant, and evaluation. It is a community approach, saying if there is a particular area or region we may want to look at, mixing some urban and rural needs. If we'd like to participate into this as a commission, it gives us an opportunity to support this collective agenda of reform and infrastructure work.

Mark Probst asked whether a digital health community had been defined; what we are trying to solve with the digital health community; were we trying to connect everybody. He emphasized it is important that we don't just connect everybody without a purpose. Joe answered that we've got to say what we're trying to define and it has to pay for itself; either in the quality or how we're going to measure that cost to the buyers.

Brad asked whether our commission would be the body that would first go after the grant and then administrate it on a statewide basis. He thinks being a broker of resources signals a fairly significant change in what we are maybe being asked to do or what we're assuming ourselves as authorized to do. He said they should be sure that that is the direction the commission wants to go if they are to become that body. Barry clarified that the commission's role would be an advisory body.

Deb asked whether there would be potentially twelve subcontracts on this particular proposal, going to twelve different communities. There would be value in having a group that could make sure the communities are heading toward the ability to connect with each other.

Wu said they planned to pass the money down to the communities. An advisory board is needed to advise what would be the best way to organize this. Jan asked if they have the legal authority to do anything like this. Brad answered that he thought that if Barry had changed the grant administrator to be the department of health then they have the authorization to do that.

Bette Vierra mentioned that they've been looking at this particular section and what the commission is interested in doing. She asked whether the definition of community could go beyond geographic areas such as the FQHC's or the community health centers. Nancy supported to broaden that scope.

Scott thought there were too many subgroups and found it is difficult to keep track of who's in what area. Joe asked if as a solution to that do you see something that you would think that UHIN would be the lead agency on this. Scott said the CVE seems to be the one that makes the most sense because there is just too much going on to keep up with.

Marc Probst said he loved the idea of helping with the cHIE and some of the expenses to connect to the cHIE are going to be out there. He thinks we can help coordinate and facilitate some of these grants to move digital health services in Utah forward. Joe said he heard interest in modifications of the funding request in looking at the readiness in the concept of a statewide community.

Brad thought they needed more time on this proposal. The needs include to convene a summit and take more time to prioritize the agenda. He said that it would make them lose focus and momentum if they put it on the regular two-hour agenda two months from now. Joe agreed that he's willing to spend additional time.

Joe proposed a vote: As a commission do we choose to pursue this grant in building e-health communities and that we do it in a way of supporting the existing efforts within standards and to promote interoperability? He takes the vote and the commission all vote in favor of it.

Other Business:

Nancy asked that since there is a feeling that strategic planning and coordinated efforts are left undone and they are needed; can they suggest what venue that might happen? Who should do

strategic planning and coordinating efforts? Sharon answered that the CVE actually have an existing task force: interconnectivity and health information technology. When the task force was created, all of the appropriate people, Scott Williams and others are in the middle of really intense efforts around the cHIE. Right now the task forces only duty is working on the cHIE. Nancy said you have to monitor, keep track and see who gets money; oversight is needed. Chet agreed saying we do need oversight and the challenge is that we have different groups working on different things.

Scott mentioned that their clinics had a 38% lost prescription rate with e-prescribing that's being run 30% of the time; the pharmacies reported that they never get the e-prescriptions. Pharmacists aren't geared with the e-prescribing tools clinics are moving down with. There is a huge failure rate of prescriptions being sent, patients showing up being told that the prescription never came from the doctors' offices. The offices were re-sending that and being frustrated. Joe suggested to talk to the business community, saying you own these businesses and you want them to function well. These are things that are happening on the executive level as well as the pharmacy level.

Meeting Evaluation and Next Steps:

Brad asked for evaluations of the meeting and next steps and then adjourned the meeting.